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## OBSERVATIONS AND SUGGESTIONS IN REGARD TO THE METHOD OF OPERATING DURING THE SAME ANÆSTHETIZATION FOR LACERATIONS OF THE CERVIX UTERI AND RUPTURED PERINEUM.

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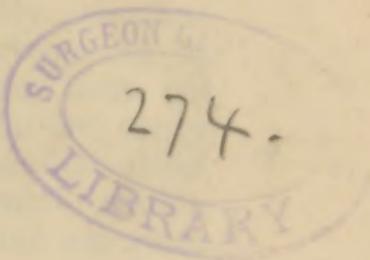
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## OBSERVATIONS AND SUGGESTIONS IN REGARD TO THE METHOD OF OPERATING DURING THE SAME ANÆSTHETIZATION FOR LACERATIONS OF THE CERVIX UTERI AND RUPTURED PERINEUM.

The two most important lesions of childbirth—laceration of the cervix uteri and rupture of the perineum—are frequently associated in the same individual. We may readily account for this coincidence in fact that the causative influences which tend to produce the one are also, in the majority of cases, at work to produce the other. Statisticians have vigorously compiled tables to show the great frequency of cervical lacerations, but no facts are available to show the relative frequency of perineal ruptures. The difficulties in the way of the collection of reliable data bearing upon this point are quite apparent. Unless we except ruptures through the sphincter ani, the lesions of the perineal body are about as difficult to classify in tables as are the spots on the moon. From a slight abrasion of

the fourchette to the complete destruction of the perineal floor back to the anal sphincter an endless variety of lesions may be observed which have more or less significance according to their influence upon the subsequent health of the patient. Lacerations of the cervix uteri are more pronounced and are more apparent to the experienced observer. The slighter lesions of the cervix more readily unite by primary union than the slight perineal tears from the fact that the wounded surfaces are less exposed to the secretions and accidents which tend to defeat union by first intention. It is from the difficulties in the way of classification that figures are wanting to show the frequency of the perineal lesion, and the relative frequency with which these lesions occur at the same time in the same individual.

Without then calling to our aid statistics to show the common occurrence of the two lesions in the same individual, we assume this fact as a part of our experience and pass to the consideration of the treatment of the two lesions at one anaesthetization. In our early professional experience the two operations, when required in the same individual, were performed at different periods, the interval extending as long as six weeks or as many months. This method of practice

was based upon the precedent of high authority and upon circumstances which were believed to exercise a more favorable influence upon the two operations as thus performed. Following the example of Sims, Eminet, and other recognized leaders, the silver wire suture was exclusively employed in our earlier experience and it is, in great measure, to this practice that we must refer our allegiance to the separation of the procedures by long intervals of time. The cervix operation was first performed, the patient being anæsthetized, and eight to ten days were allowed for union before the wire sutures were removed. During all this time the patient was kept in the recumbent posture. After the removal of the sutures a number of weeks were permitted to intervene before the perineal operation was approached. In the meantime hot-water douches, tonics, etc., were advised in order that the patient might be placed in the very best condition for the second procedure. A second anæsthesia and the details of a second operation were now gone through with for the closure of the perineum, and eight or nine days of subsequent nursing and, not infrequently, as many weeks of subsequent convalescence were the outcome of the second procedure..

The details and disadvantages of this method of operating are as real as they are apparent. The effects of two separate methods of procedure upon the patient were far from salutary, whilst to the operator the anxiety and labor were more than twofold. After an experience with the methods of separate procedures we were not regretful when an opportunity came to abandon them. This opportunity presented itself when the cat-gut suture became one of the popular additions to our armamentarium.

Having tenaciously held on to the silver suture we were loath to abandon it for its now more popular rival, but the acceptance of the new for the old worked a complete change in the method of operating, and has so modified our views in regard to the treatment of these two lesions that we now occupy an entirely different relation to them. Latterly, we have invariably practiced the method of closing both lesions whilst the patient is under the influence of the anæsthetic, with results so simple and satisfactory that we seldom see just ground for separating the interval between the two operations.

The method of procedure is this: The patient is first prepared for operation by so many days or weeks of prior treatment as her condition de-

mands. When she is in suitable health a day is set apart and the early morning selected, say the hour of 10 o'clock, for the operation. The patient is anaesthetized, and then placed in Sims' position. The edges of the torn cervix are properly pared and brought together with anti-septic cat-gut sutures. Beginning at the angle of the flaps the sutures are passed in parallel rows and as near to each other as they can be conveniently inserted. Three, four, five, or six sutures, or more, if required by the length of the flaps, are employed. The wound is now brought into close apposition and the sutures are tied, commencing with the one nearest the angle of the wound. After the flaps are in this way drawn together and adjusted a single wire suture is passed through each flap on both sides at the cervical opening. These are twisted to the required degree and the ends so cut off that the end-points cannot irritate or wound the vaginal tissues. This is best accomplished by converting the wire into a spiral and turning the end-points into the hollow of the spiral. The wire sutures are used as fixation sutures and on the theory that the strain upon the suture is greatest at the end of the cervical stump. It has never been found necessary to use more than one wire suture, on each side though in a case of an unusually

long flap or very thick cervix either silk or wire would be employed if necessary. The cat-gut suture has acted very satisfactorily in our experience. By the end of the eighth or tenth day it will most probably have disappeared by absorption, but in this there is an evident advantage. Primary union must result in from 48 to 72 hours, if it takes place at all, and the cat-gut suture, if of any value at all, will continue to hold the flaps in apposition until this time. We have found the cat-gut suture in position as late as the fourteenth day after the operation.

Having closed the cervix after the manner described, the patient is changed from Sims' to the recumbent posture, the perineal border is abraded of its mucous surface, and the tissues are brought together after the method of the perineal operation as advised by Dr. Eminet, or such modifications of it as may be indicated in the case. The perineum thus closed the patient is lifted into her bed and treated as after an ordinary operation for the closure of the perineal body. At the expiration of eight days the perineal sutures are all removed. The wound is bathed in antiseptic washes and the vagina is likewise syringed out with antiseptic injections. The patient is enjoined to remain quiet for the next five

or six days, and usually by this time the perineal wound is so far well that the finger or speculum can be used to examine the cervix. Usually the sutures from the cervix are removed on the fourteenth or sixteenth day after the operation. Convalescence is rapid after this. During the operation every attention is given to cleanliness, and antiseptics—chiefly the bi-chloride of mercury 1 to 4,000—are carefully employed. Haemorrhage has never proved to be a troublesome complication of the two procedures. The time required for both operations is from one hour to one hour and a half. This can be expedited by having an abundance of needles, sponges, and other instruments required for expeditious work. If the operator stops in the middle of an operation to talk, or to thread needles, or to sponge, he should not charge this delay to the operation. He should have assistants and nurses to hand him instruments and to render necessary attentions, thus avoiding a very tedious and tiresome procedure. The results of these operations by the method here related have been just as satisfactory as by the old method in point of relief afforded the patients, whilst from the standpoint of comfort to patient and operator the gain has been immense.

By the conjoint method we gain, *first*, the closure of two lesions whilst the patient is under the anæsthetic. This is in itself a most important advantage to both patient and operator. We gain, *second*, a period of confinement to bed of about two weeks and a single convalescence, as compared with the weeks given to the operation at separate intervals and the anxiety and dread—born of experience—which were inseparable from this method. In the *third* place we save time and suffering by condensing two grave procedures into a single procedure which does not increase the danger in proportion to its apparent gravity. *Fourth*, the results of union are just as satisfactory by the new as by the old method.



